

Directions for using the Pre-transport Stabilization Self-Assessment Form

1. Either during pre-transport stabilization care, or immediately after the infant is transported, complete the demographic information in the Patient Information section of the form.
2. Under Indications for Referral, select all of the suspected or confirmed diagnoses that apply at the time of referral.
3. Times A, B, and C are used repetitively on the first and second pages of the form.

   Record the vital signs, physical exam, and stabilization procedures that were performed:

   - At the time the transport team was called (transport was requested) = **Time A**
   - Upon arrival of the transport team in your nursery = **Time B**
   - Upon departure of the transport team = **Time C**
     - The transport team should help complete the Time C items, unless the infant is unstable and time does not allow. In that case, if at all possible, ask the team to leave a copy of their stabilization record so you can complete the Time C items.
4. Completion of this form will allow evaluation of stabilization care by looking at three specific time intervals:
   - What stabilization actions were taken at the time it was determined the infant was sick?
   - What stabilization actions were taken while awaiting the team's arrival?
   - What stabilization actions were completed by the team?

   The following scenarios are possible:

   - The team arrives and stabilization is complete so they do not need to do more than assess the baby, attach the transport equipment and move the baby into the incubator.
   - The team arrives quickly and completes the stabilization procedures that you did not have time to complete.
   - The team arrives and determines that additional care is needed, and therefore, additional actions are taken (such as intubating the patient, inserting lines, changing an ET tube, administering certain medications, etc.).
   - By recording these actions, it is hoped that the nursing and medical leadership team will be able to assess adequacy of pre-transport (or transfer) stabilization care.
   - In addition, this important review process may be very helpful for identifying simulation education activities that may help prepare for similar future events.

If you have trouble filling out the form, or you need additional expertise to answer the questions on the third page of the form, then your transport team should be consulted for assistance. An optimally performed stabilization is the goal of community caregivers and transport teams alike!

Pre-transport Stabilization Self-Assessment Tool (PSSAT)

PARENT INFORMATION

Birth weight: ☐☐☐☐ grams **Birth order:**____of____

Growth: AGA SGA LGA **Gender:** Male Female Ambiguous

Estimated Gest. Age: ☐☐-☐/☐ weeks/days (ex: 34-3/7)

Baby admitted from: ☐ Labor & Delivery ☐ Mother-baby unit ☐ Nursery ☐ Emergency room

Resuscitation at birth: Suction Blow-by oxygen CPAP CPAP & PPV Intubation & PPV Chest compressions

Resuscitation meds (list):_____

Other meds (list):_____

Apgar at 1 minute: ☐☐ 5 min: ☐☐ 10 min: ☐☐ 15 min: ☐☐ 20 min: ☐☐

Indications for referral (circle all that apply)

Prematurity Respiratory distress Sepsis Cardiac Metabolic Genetic Neurologic Hematologic Surgical Birth depression

Other (explain): _____

TIME

Age of baby in Days and Hours after birth – **at time transport team called** _____**Days** _____**Hours**

A Transport team called _____ AM PM

B Transport team arrived at nursery _____ AM PM

C Transport team departed nursery _____ AM PM

Note: these times will be used throughout this form. When answering questions, evaluate the parameter closest to time A, B, and C.

Time patient died; transport aborted _____ AM PM (complete remainder of form even if patient died)

VITAL SIGNS

	Temperature °C °F	Axillary or Rectal	Heart Rate	Respiratory Rate	Blood Pressure Systolic/Diastolic	Mean	Method (RA, LA, RL, LL) *or* Arterial
Time A					/		
Time B					/		
Time C					/		

PHYSICAL EXAM

Perfusion/Pulses

	Capillary Refill Time (sec.) over chest	over knee		Pulses			Pulses equal upper & lower		(If no,explain)
Time A			sec.	Normal	Decreased	Increased	YES	NO	
Time B			sec.	Normal	Decreased	Increased	YES	NO	
Time C			sec.	Normal	Decreased	Increased	YES	NO	

Retractions

	Severity (circle all that apply)				Location (circle all that apply)			O_2 Saturation	FiO_2
Time A	Mild	Moderate	Severe	Gasping	Substernal	Intercostal	Subcostal	%	%
Time B	Mild	Moderate	Severe	Gasping	Substernal	Intercostal	Subcostal	%	%
Time C	Mild	Moderate	Severe	Gasping	Substernal	Intercostal	Subcostal	%	%

Level of consciousness **Response to noxious stimuli** (circle all that apply) **Other** (explain)

Time A	Withdraws/good tone, cries	Lethargic, no cry	Seizure(s)	No response, comatose	
Time B	Withdraws/good tone, cries	Lethargic, no cry	Seizure(s)	No response, comatose	
Time C	Withdraws/good tone, cries	Lethargic, no cry	Seizure(s)	No response, comatose	

Paralytic used (i.e. pavulon)? Yes No Reason given: _____

Time/dose of all Opioids given past 24 hrs (list type) _____

Time/dose of all Sedatives given past 24 hrs (list type) _____

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STABILIZATION PROCEDURES

Use Time **A B C** from page 1	**Time A** _____	**Time B** _____	**Time C** _____
IV in place?	Y N Location _____	Y N Location _____	Y N Location _____
IV fluid infusing?	Y N Type _____ Rate ml/kg/day _____	Y N Type _____ Rate ml/kg/day_____	Y N Type _____ Rate ml/kg/day_____
UVC in place?	Y N Tip location _____	Y N Tip location _____	Y N Tip location_____
UAC in place?	Y N Tip location _____	Y N Tip location _____	Y N Tip location _____
Glucose – closest to 15 – 30 minutes of this time	Y N Value mg/dL _____	Y N Value mg/dL _____	Y N Value mg/dL _____
Glucose bolus given?	Y N Fluid _____ Amount _____	Y N Fluid _____ Amount _____	Y N Fluid_____ Amount _____
Oxygen in use?	Y N % _____	Y N % _____	Y N %_____
Pulse oximetry on?	Y N O_2 sat_____	Y N O_2 sat _____	Y N O_2 sat _____
CPAP in use?	Y N Type _____ Pressure _____	Y N Type_____ Pressure _____	Y N Type_____ Pressure _____
PPV provided?	Y N Pressures _____ Rate _____	Y N Pressures _____ Rate _____	Y N Pressures _____ Rate _____
Tracheal intubation?	Y N Cm at lip _____	Y N Cm at lip _____	Y N Cm at lip _____
ET tube properly secured?	Y N	Y N	Y N
Chest tube in place?	Y N	Y N	Y N
Chest needle or cath placed?	Y N	Y N	Y N
Volume bolus?	Y N Type _____ Amount _____	Y N Type _____ Amount _____	Y N Type _____ Amount _____
On dopamine?	Y N Dose mcg/kg/min _____	Y N Dose mcg/kg/min _____	Y N Dose mcg/kg/min _____
CBC with differential done?	Y N	Y N	Y N
Blood culture drawn?	Y N	Y N	Y N
Antibiotics given?	Y N	Y N	Y N Additional antibiotic or dose given?
On radiant warmer on ISC?	Y N	Y N	Y N
In incubator on ISC?	Y N	Y N	Y N
In incubator on air temp?	Y N	Y N	Y N

BLOOD GASSES

Time	Indicate CBG, ABG, Venous						**Ventilation settings** PIP/PEEP	Rate	**FiO_2**	**Method** B/M? Prongs? Hood Intubated
AM PM	☐	pH _____	pCO_2 _____	pO_2 _____	HCO_3 _____	BE _____	_____ /_____	_____	_____%	_____
AM PM	☐	pH _____	pCO_2 _____	pO_2 _____	HCO_3 _____	BE _____	_____ /_____	_____	_____%	_____
AM PM	☐	pH _____	pCO_2 _____	pO_2 _____	HCO_3 _____	BE _____	_____ /_____	_____	_____%	_____

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SPECIFIC INTERVENTIONS

Airway

ET tube location (cm marking **at the lip**) **when Team arrived:** _____cm

Was ET tube location readjusted **prior** to the transport team arrival? Y N Explain:_____

Was ET tube location readjusted **after** transport team arrival? Y N Explain:_____

Was patient **re-intubated** by the transport team? Y N Explain:_____

Other: _____

Antibiotics

Time _____ AM PM Order for antibiotics given Order was (Circle one) Written Verbally given

Time _____ AM PM Blood culture obtained

Time _____ AM PM Antibiotic 1 begun (name/dose) _____

Time _____ AM PM Antibiotic 2 begun (name/dose) _____

Other stabilization efforts not yet described: _____

_____

SELF-EVALUATION QUESTIONS

Healthcare providers involved with this stabilization (to be completed by initial healthcare facility providers). Healthcare provider who requested the transport: ☐ Family practice ☐ Pediatrician ☐ Neonatologist ☐ Midwife ☐ Nurse Practitioner ☐ Physician Assistant

Was physician or primary healthcare provider PRESENT at patient's bedside or in nursery at the time of transport team arrival?

☐ Yes ☐ No (If no, explain):_____

TIME consultations made: _____ AM PM Family practice called _____ AM PM Pediatrician called _____ AM PM Neonatologist called

Provide name or initials of other healthcare providers involved with this stabilization:

Nurse (RN) _____

RT_____ LPN _____ Nurse Assistant_____ Other:_____

1. **We feel our strengths with this stabilization effort were:** _____

_____

The following people should be commended: _____

_____

2. **We feel our weaknesses with this stabilization effort were:** _____

_____

3. **We encountered the following barriers that altered our ability to work as a team:**_____

_____

4. **We wish we had the opportunity to learn more about** (list all educational needs):_____

_____

5. **We encountered the following problems that affected our ability to perform the stabilization we would like to perform** (include equipment malfunction or equipment not available, slow response times from other healthcare departments, uncertainty about the diagnosis, communication issues, etc). _____

_____

_____

6. **The next time we have to stabilize a sick neonate, we would change the following:**_____

_____

NAME OF PERSON completing this form & date: _____